Section 4.2 Behavioral Health Medical Record Standards

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4.2.1 Introduction

Maintaining current, accurate and comprehensive behavioral health medical records for persons who receive behavioral health services is important for many reasons. Documentation in the behavioral health medical record facilitates the diagnosis and treatment of persons, but it also supports billing reimbursement information, lends to compliance during periodic medical record reviews and can protect practitioners against potential litigation. The behavioral health medical record contains a wealth of clinical information pertaining to the behavioral health recipient; information that can assist behavioral health providers in successfully treating and supporting the individual.

Medical record documentation must be legible and accurate and reflect a behavioral health recipient's behavioral health status, changes in behavioral health status, behavioral health care needs and behavioral health services provided.

ADHS/DBHS recognizes the value of an accurate and comprehensive behavioral health record. As such, ADHS/DBHS has established the standards in this section to guide behavioral health providers in ensuring the proper organization, content, maintenance and retention of behavioral health medical records.

4.2.2 References

The following citations can serve as additional resources for this content area:

- A.R.S. § 12-2294
- A.R.S. § 12-2297
- R9-20-211
- AHCCCS/ADHS Contract
- ADHS/T/RBHA Contract
- AHCCCS Medical Policy Manual, Policy 940
- Advance Directives Section
- Intake, Assessment and Service Planning Section
- Co-payments Section

- Reporting of Incidents, Accidents and Deaths Section
- Enrollment, Disenrollment and other Data Submission Section
- Disclosure of Behavioral Health Information Section
- General and Informed Consent toTreatment Section

4.2.3 Scope

To whom does this apply?

All persons receiving, or who have received, behavioral health services.

4.2.4 Did you know…?

- The behavioral health record is the property of the entity that generates the record.

- AHCCCS or the Federal government may inspect Title XIX and Title XXI behavioral health medical records at any time during regular business hours at the offices of ADHS/DBHS, the T/RBHAs or behavioral health providers.

4.2.5 Objectives

To establish standards to ensure that each behavioral health record is complete, accurate, legible and current.

4.2.6 Procedures

4.2.6-A. Paper or electronic format

Records may be documented in paper or electronic format.
For paper documentation the record must be:

- Dated;
- Signed with an original signature and credential;
- Legible and either written in black or typewritten; and
- Be corrected with a line drawn through the incorrect information, a notation that the incorrect information was an error, and the initials of the person altering the record. Correction fluid or tape is not allowed.

For electronic documentation there must be a method to:

- Indicate the identity of the person making an entry into the record;
- Assuring that the information is not altered inadvertently; and
- Track when, and by whom, revisions to information are made.

4.2.6-B. Retention of records

Records must be retained:

- For an adult, for at least seven years after the last date the adult person received medical or health care services from the T/RBHA or behavioral health provider;

- For a child, either for at least three years after the child's 18th birthday or for at least seven years after the last date the child received medical or health care services from the T/RBHA or behavioral health provider, whichever occurs last.

4.2.6-C. Disclosure of records

- Behavioral health records must be maintained as confidential and must only be disclosed according to the provisions in Section 4.1, Disclosure of Behavioral Health Information.

- Section 4.1, Disclosure of Behavioral Health Information, contains information regarding the review of behavioral health medical records by behavioral health recipients.

- When requested by a person's primary care provider, the behavioral health record or copies of behavioral health record information must be forwarded within 10 days of the request.

4.2.6-D. Comprehensive clinical record

The designated clinical liaison must oversee to ensure the development and maintenance of a comprehensive clinical record for each enrolled person. The comprehensive clinical record can contain information contributed by several other service providers involved with the care and treatment of a person.

The comprehensive clinical record must contain the following elements:

- Documentation of Title XIX or Title XXI eligibility verification;

- If not Title XIX or Title XXI eligible, information regarding any co-payments assessed;

- Contact information for the persons primary care provider (PCP), if applicable;

- Identification information on each page of the record (i.e., name or identification number);

- Documentation of required demographic information (see Section 7.5, Enrollment, Disenrollment and other Data Submission);

- Documentation of all information collected in the Core Assessment, including any applicable addenda (see Section 3.9, Intake, Assessment and Service Planning);

- The person's treatment and service plan;

- Documentation, initialed and dated by the person's clinical liaison to signify review of:
  - Diagnostic information including psychiatric, psychological and medical evaluations;
  - Reports from providers of services, consultations and specialists;
  - Emergency/urgent care reports; and
  - Hospital discharge summaries;

- Receipt of the Member Handbook;

- Copies of any advance directives or mental health power of attorney as defined in Section 3.12, Advance Directives, if applicable;

- Documentation of general and informed consent to treatment pursuant to Section 3.11, General and Informed Consent to Treatment;
- Authorization to disclose information pursuant to Section 4.1, Disclosure of Behavioral Health Information;
- Documentation of any review of behavioral health record information by any person or entity (other than members of the collaborative team) which includes the name and credentials of the person reviewing the record, the date of the review and the purpose of the review;
- Documentation of the provision of diagnostic, treatment and disposition information (as allowed in Section 4.1, Disclosure of Behavioral Health Information) to the PCP and other providers to promote continuity of care and quality management of the person's health care;
- Discharge summaries from previous behavioral health treatment;
- Documentation of Certification of Need and Re-Certification of Need, when applicable;
- Laboratory, x-ray and other findings related to the person's behavioral health care;
- Affiliation with other state agencies;
- Medication record, when applicable; and
- Documentation of any requests for and forwarding of behavioral health record information.

4.2.6-E. Behavioral health provider records

Often times, a person may receive behavioral health services from multiple behavioral health providers. Behavioral health providers that are licensed through the Office of Behavioral Health Licensure (OBHL) must maintain a behavioral health record that meets the requirements of A.A.C. Title 9, Chapter 20 (see R9-20-211). In addition, OBHL licensed behavioral health provider records must include:

- Progress notes including:
  - Documentation of the type of services provided;
  - The date the service was delivered;
  - Duration of the service;
  - A description of what occurred during the provision of the service related to the person's treatment plan; and
  - The person's response to service.
- Periodic summary of the person's progress towards treatment goals;
- Physician and practitioner orders for the service;

- For OBHL licensed Level I facilities, documentation that any serious occurrence or death involving a behavioral health recipient (see Section 7.4, Reports of Incidents, Accidents and Deaths):
  - Has been reported to AHCCCS and the Arizona Center for Disability Law (ACDL); and
  - A copy of the information reported to AHCCCS and ACDL; and
  - In the case of a behavioral health recipient's death, that the information above has also been reported to the Center for Medicare and Medicaid Services.

- Applicable diagnostic or evaluation documentation; and

- Signature/initials of the provider for each service.

Behavioral health providers must send to the person's clinical liaison copies of any information maintained in their own behavioral health record that must also be maintained in the comprehensive clinical record. See 4.2.6-D. for the elements that must be included in the comprehensive clinical record,

(T/RBHA insert specific information here)

4.2.6-F. Requirements for community service agencies, therapeutic foster care homes for children and habilitation providers

Community Service Agencies, Therapeutic Foster Care Homes for Children and Habilitation Providers must maintain records that include:

- The name of the person receiving services;

- Emergency contact information; and

- Other documents as determined by the T/RBHA.

[T/RBHA insert language here]